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Agoraphobia and space phobia

It is over 100 years since Westphal[1] gave the name agoraphobia to a group of symptoms experienced by patients walking in streets or open spaces. These consist in dizziness, anxiety, palpitations, and trembling, and Westphal singled out anxiety as the central symptom. In this he differed from his contemporary Benedikt, who a year earlier had described similar cases and concluded that dizziness was the core problem.[2] Benedikt went on to suggest that this dizziness was caused by a disorder of the ocular muscles, a suggestion that Westphal rejected.

Since these original reports the concept of agoraphobia has been retained. Westphal's important paper was based on detailed observations of only three patients; rather surprisingly all were men, for two-thirds of most subsequent series of patients with agoraphobia have been women.[3] Nevertheless, Westphal's men had much the same fears that agoraphobic patients tell their doctors about today: they felt anxious not only in the street but also in crowded places indoors; and, like our patients today, they were less anxious when a trusted companion was present. Nowadays our agoraphobics tell us about anxiety in crowded shops and buses, rather than the churches and theatres that Westphal described, but these variations reflect social changes rather than any fundamental difference in the disorder. Modern accounts of agoraphobia also emphasise that anxiety is not just an automatic response to circumstances: the patient's thoughts are also important both at the time he enters these places and when he anticipates doing so. Though this aspect of the disorder was not emphasised by Westphal, the phenomenon is not new, for it was referred to by Cordes[4] in a paper written in the same year.

Despite this reassuring sameness of the clinical picture over the years some authors doubt whether agoraphobia is a primary syndrome. Thus Snaith[5] has written that it is "a misleading diagnostic label for a group of conditions which are not homogeneous and have in common only a certain type of feared situation," and others have expressed similar doubts.[6 7] They point out that fears of going out into open spaces and crowds are common in anxiety states and depressive disorders and go on to suggest that whenever these phobic symptoms occur they are merely an unimportant addition to the primary disorder—an addition that may alter the patient's need for treatment in certain ways but does not justify the recognition of a separate syndrome. If such views were correct the supposed primary disorders might be expected to emerge more clearly as patients are followed up for several years. The results of few follow-up studies are available, but those that have been carried out show that this does not happen.[8 9] Instead, agoraphobic patients continue to show the agoraphobic syndrome; they do not exchange it for an anxiety state or depressive disorder, nor does another disorder appear when they are treated with behavioural treatment directed to the agoraphobic symptoms. So, while the matter cannot be said to be settled without any doubt, the balance of evidence favours a separate syndrome of agoraphobia.

Given that conclusion, care must be taken that the diagnosis is applied correctly and that other conditions are not mistaken for agoraphobia. To maintain that there is an agoraphobic syndrome is not to deny that some of the symptoms included in the syndrome can appear at times in other conditions. This happens most commonly in anxiety states and depressive disorders, but Marks has recently drawn attention to another condition which can be mistaken for agoraphobia.[10] He calls it space phobia or pseudoagoraphobia.

Marks described 13 patients whose symptoms resembled those of agoraphobia to the extent that several had been diagnosed as such, but whose disorder differed in four important ways. Firstly, the condition began when the patients were older—on average aged 55 compared with 25 among agoraphobics. Secondly, their fears were not the same as those of the agoraphobics. They feared falling and were anxious in open spaces because they had no immediate means of support; they were not anxious in the crowded public places characteristic of agoraphobia. Thus one of Marks's patients could dance when the floor was crowded but felt anxious as soon as it cleared of people, and another said, "The fear is of space around me." Some patients could get about only by crawling because they experienced so much anxiety when standing up. Thirdly, they responded less well to behavioural treatments based on returning patients repeatedly to the circumstances they avoided. Finally, 10 of the 13 had evidence suggesting organic disease of the brain or cardiovascular system, including tinnitus, cervical spondylosis, pyramidal and cerebellar signs, nystagmus, hypertension, and carotid bruit. Marks argues, not entirely convincingly, that these diverse abnormalities reflect a common disorder, most probably a derangement of oculovestibular mechanisms, which might account for the fear of falling. This idea has interesting similarities to Benedikt's explanation of agoraphobia itself, but it is more convincing when applied to this restricted group of patients with their special pattern of fears and with more evidence of a pathological basis.

Both these aetiological issues, and the question whether space phobia is a useful diagnostic category, will be easier to answer when the patients have been followed up for longer. Clinicians who have seen many cases of agoraphobia will recognise the clinical picture which Marks has described, but they would probably regard it as rare. The report of these cases is, however, a reminder of the general importance of seeking carefully for organic factors whenever a neurotic syndrome appears for the first time in a patient who is in middle age. And that is a lesson which cannot be repeated too often.

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